SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

HOME AND COMMUNITY BASED WAIVER Policy Manual	Section: ADMINISTRATIVE REQUIREMENTS
	Subject: Payment Processing

REQUIREMENT

Providers of Home and Community Based Services must be enrolled as a Medicaid provider. Payment for services must be made directly to the provider of service. No payment may be made to the member or any entity other than the provider of services unless otherwise specified by the Department.

Under certain rare circumstances, HCBS case management teams may act as a pass through and bill for a service provided by another entity to facilitate payment, when a member goes out-of-state, for a one-time purchase, or a temporary service. When billing for a service provided by another entity, the CMT must obtain an invoice for the cost of the service. The CMT may not add on a charge for processing the claim.

CLAIM FORM

The provider requests payment from Medicaid by submitting a claim to XEROX. Claims may be submitted electronically or in paper form using the CMS-1500. (Refer to Appendix 699-2).

CASE MANAGEMENT TEAM (CMT) APPROVAL

All Home and Community Based Services, except case management, must be prior authorized by the CMT. The prior authorization number must be noted on the CMS-1500 or 837-P for all submitted charges. Refer to the Prior Authorization Manual for instructions to create, change or deny prior authorizations.

The CMT must establish more than one prior authorization number for a member in a time period, if there is more than one provider providing the same service at the same time, such as personal assistance, or moving from one AL facility to another. This will eliminate the chance of one provider billing for more units than they were authorized and the other provider having their claims denied.

The CMT must send providers a referral the with prior authorization number information. Refer to form 699-5 for a sample referral. The referral must include the following information:

1. Provider's name and Medicaid HCBS provider number (if known).
2. Member's name, address, telephone number and date of birth.
3. Member's Medicaid ID number.
4. Member's primary diagnosis and ICD-9 code.
5. Prior authorization number and date span.
6. List of procedure codes and modifier this provider is authorized to provide and bill.
7. Dollar amount or number of units and date span for each service. To avoid overbilling, it is preferable to use dollar amounts when the service has an upper limit and the provider could erroneously bill at the higher rate.
8. Any comments that would benefit the provider; e.g., number of hours per week.
9. Case management contact person and telephone number.

The CMT must end-date the prior authorization at discharge of a waiver member.

PAYMENT DEADLINES

XEROX must receive a provider's clean claim no later than 365 days from the date services were provided in order to be reimbursed by Medicaid.

QUESTIONS ON CLAIMS

Questions about the filing of claims or payments should be directed to:
XEROX
1-800-624-3958 or (406) 442-1837; or
Community Services Bureau at (406) 444-4376.